

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

07977

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:

County... Dorchester

City or town... Vienna - Rural

(If outside city or town limits, write RURAL and give nearest town)

life

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Indiantown Road

How long in hospital or institution?

3. (a) FULL NAME

Sophronia H. Bradley

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Henry Bradley

7. Birth date of deceased (mo., day, yr.)

June 1, 1876

6.(c) If alive, give age years

8. AGE:

Years
69Months
2Days
3If less than one day
hrs. min.

9. Birthplace

Dorchester County, Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Home

MOTHER FATHER

12. Name

Thomas Maine

MOTHER FATHER

13. Birthplace

Dorchester County, Maryland

MOTHER FATHER

14. Maiden name

Elizabeth Fischer

MOTHER FATHER

15. Birthplace

Dorchester County, Maryland

MOTHER FATHER

16. Informant

Mrs. T. Graham Craver

Address

Richmond, Virginia

17. Burial

Date thereof August 6, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Brookview Cemetery

Location

Brookview, Maryland

18. Funeral director

J. J. Frampton & Son

Address

Federalsburg, Maryland

19.

Aug 6 - 1945

- 1945

Charles Hartman

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... Dorchester

City or town... Vienna - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No... Indiantown Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 4 1945 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1945 to Aug 4 1945

and that I last saw her alive on Aug 1 1945

Immediate cause of death

Embolic stroke of brain due to disease of the heart causing complete hemiplegia

Due to... arteriosclerosis,

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J. J. Frazer M. D. or other

Address... Brookview Cemetery Date signed Aug 6-1945

RECEIVED

AUG 14 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of sex & color is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07978

Reg. Dist. No. 116

HLM G 97 SEP 5 1945

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Disney Bremock

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

6. (b) Name of husband or wife

Mandy Bremock

6. (c) If alive, give age

Deced

years

7. Birth date of deceased (mo. day, yr.)

P.

1870

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Taylor Island Md.

(Town, county, and state)

10. Usual occupation

Boilerer

11. Industry or business

Dont know

12. Name

Dont know

13. Birthplace

Dont know

14. Maiden name

Dont know

15. Birthplace

Alida Bank

Address Cambridge Md

16. Informant

Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug 26 1945

(month day year)

Cemetery

Location Taylor Island Md

18. Funeral director

Spurts B. Bayman

Address Cambridge Md

VS A15 8-27-45

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Aug 23 1945 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 4 1945 to Aug 23 1945

and that I last saw him alive on Aug 17 1945

Immediate cause of death Cerebral Hemorrhage

DURATION 21 days

Due to

Due to

Other conditions

Hypertension

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carroll M. Cleary M. D. or other

Address Ann Arbor MI Date signed 8-25-45

MB



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

CERTIFICATE OF DEATH

07979

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Baltimore
 City or town Cambridge Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2 days

3. (a) FULL NAME

William J Chesneau

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)
July 1st 1878

8. (c) If alive, give age

years

8. AGE: 67 Years Months 1 Days If less than one day
hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Petited Merchant

11. Industry or business

William J Chesneau

12. Name

Mary Allen More

13. Birthplace

Madison

14. Maiden name

Cemetery

15. Birthplace

East New Market

16. Informant

B. W. Willoughby

17. Burial

Date thereof Sept 1st 1941
(Burial, cremation, or removal which?)

(month) (day) (year)

Cemetery or crematory

LocationEast New Market18. Funeral directorAddressJohn DeardorffDec 1st 1945RegistrarJ. J. EdwardsCambridge, Md.Date signed8/30/45(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State CountiesCity or town (If outside city or town limits, write RURAL and give nearest town)Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1945 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 29 1945 to Aug. 30 1945and that I last saw him alive on August 30 1945Immediate cause of death TOXIC MYOCARDITISDURATION 7 daysDue to GANGRENE RT. FOOT.DURATION 62 daysDue to DIABETES MELLITUSDURATION 7 daysOther conditions ADENOCARCINOMARECTUM

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature J. J. Edwards

M. D. or

Address Cambridge, Md.Date signed 8/30/45

RECEIVED
SEP 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

07989

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County... Dorchester
 City or town... Delancey Rd., near Deaford Del.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs.

Hospital, Institution, or street address where death occurred:
 2700

How long in hospital or institution? no

3. (a) FULL NAME

Mrs Rose Hukes

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white Widowed

6.(b) Name of husband or wife... Willis Hukes
 deceased

7. Birth date of deceased (mo., day, yr.) April 12, 1877

8. AGE: Years Months Days If less than one day
 68 4 14 hrs. min.

9. Birthplace... near Federalsburg
 (Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

12. Name... Mrs. J. Morgan

13. Birthplace... Maryland

14. Maiden name... Mary Elizabeth Andrew

15. Birthplace... Maryland

16. Informant... Mrs. Mary Burd

Address... Wilmington, Delaware

17. Burial... Cemetery Date thereof... Aug 30, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Blooming Cemetery

Location... near Federalsburg

18. Funeral director... F. Harvey W. Dawson

Address... Federalsburg, Md.

19. Aug 30 1945 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State... Maryland County... Dorchester

City or town... Delancey
 (If outside city or town limits, write RURAL and give nearest town)

Street No... near Deaford Del
 (If rural, give LOCATION)

2.(a) If veteran, name war... no

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH... August 26, 1945, at 11:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 26 1945 to Aug 26 1945 and that I last saw her alive on Aug 26 1945

Immediate cause of death... Cerebral Hemorrhage

Due to... Asthma

Due to... Other conditions High blood pressure

(Include pregnancy within 8 months of death)

Major findings or operations... Date of op.

Autopsy results... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

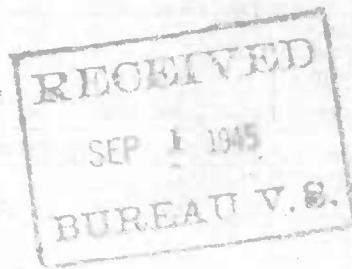
Means of injury... Injured at work?

23. SIGNATURE... S. A. B. Allen

M. D. or other

Date signed Aug 27/45

Address... Deaford Del



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 730

07981

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County..... Dorchester

City or town..... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos. 25 ds

Hospital, Institution, or street address where death occurred:

Eastern Shore State Hosp.

How long in hospital or institution? 6 mos 2 ds

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

Cheyandville County..... Kent

City or town..... Chesterville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(u) Is veteran, name war..... no

3. (a) FULL NAME

Harry E Dwyer

3. (b) Social Security Number
none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) December 13 1895

8. AGE: Years Months Days It less than one day
49 8 mos 14 hrs. min.9. Birthplace..... Worton Kent Maryland
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

12. Name..... William Dwyer

13. Birthplace..... Kent County Mar land

14. Maiden name..... Mary R. England

15. Birthplace..... Kent Cy. Maryland
Hospital Records

16. Informant.....

Address..... Cambridge Maryland

17. Burial Date thereof Aug 30 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... CHESTER VILLE CEM.

Location..... KENT co. Md.

18. Funeral director..... J. Willis Wells

Address..... Chestertown, md

19. 8-27-1945 John Macyle M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 27 1945 at 10.45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 2 1945, to August 27 1945, and that I last saw him alive on August 27 1945

Immediate cause of death.....

Chronic Myocarditis &
Myocardial Degeneration

Due to..... Arteriosclerosis

Due to.....

Other conditions..... Chronic Bronchitis

Emphysema
(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury

Injured at work?

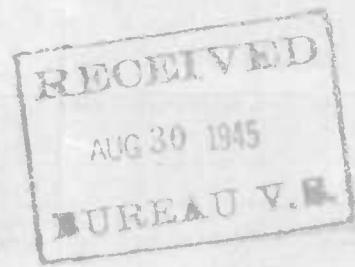
23. SIGNATURE.....

D.

M. D. or other

Address..... Cambridge, Md.

Date signed..... August 27 1945



M
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12-21

07982

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:

County.....

Dorchester
Hurstlock - Rural

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 months

Hospital, Institution, or street address where death occurred:

P.W. Camp No. 5

How long in hospital or institution?

3. (a) FULL NAME

George Elgarter

316-1823484

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed or divorced

?

5. (b) Name of husband or wife.....

?

7. Birth date of

deceased (mo., day, yr.)

1904

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

41

#

#

#

hrs.

#

9. Birthplace.....

Seamans

(Town, county, and state)

10. Usual occupation.....

W.P.

11. Industry or business

7

MOTHER FATHER

12. Name.....

?

13. Birthplace

7

14. Maiden name.....

?

15. Birthplace

7

16. Informant.....

Camp Records

Address

P.W. Camp #5 - Hurstlock

17.

(Burial, cremation, or removal. Which?)

Date thereof Aug. 16 1945
(month) (day) (year)

Cemetery or crematory.....

Ft. Goo Roads

Location.....

Md.

18. Funeral director.....

H.J. Brumy

Address

Ft. Goo Roads

19. Date record by registrar.....

Aug. 14 1945

(Date record by registrar)

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

Dorchester

City or town.....

Hurstlock - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

P.W. Camp No. 5

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug 13

1945 at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18.....

to.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

Gastro-Enteritis

DURATION

Due to.....

Ptomaine ?

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

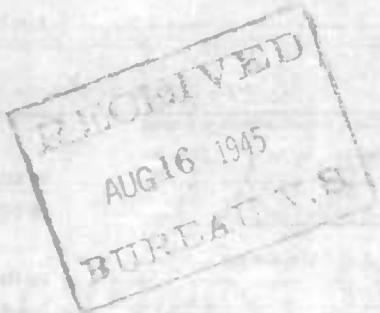
23. SIGNATURE.....

M. D. or other

Address.....

Cambridge - Md.

Date signed Aug 14 1945



AUG 16 1945

1
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 488

07984

FILM NO. G 97 AUG 31 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County

City or town

Dorchester

Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

32 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Ella Fitzgerald

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female Negro

Widowed

6. (b) Name of husband or wife

William Fitzgerald

7. Birth date of deceased (mo., day, yr.)

Feb 11 - 1895 1891

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

54

6

2

hrs.

min.

9. Birthplace

Sharptown W.C. Co Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

12. Name

Daniel R. Shockley

13. Birthplace

Somerset Co. Md

14. Maiden name

Mary Sheppard

15. Birthplace

Somerset Co. Md.

16. Informant

Henry Shockley

Address

Cambridge, Md

17. Burial

Burial, cremation, or removal. Which? Date thereof Aug 16 1945

(month)

(day)

(year)

Cemetery or crematory

Waugh Cemetery

Location

Cambridge Md

18. Funeral director

N.M. Fitzgerald

Address

Cambridge, Md

19. (Date rec'd by registrar)

8-13-45

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Dorchester

City or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 409 Pine St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

8 MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1 1945 to August 13 1945 and that I last saw her alive on August 13 1945.

Immediate cause of death

Carcinoma Uteri

DURATION

8 mo

Due to

Due to

Other conditions

Hypertension

10 mo

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

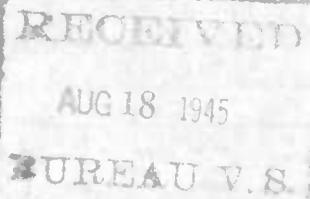
Conroy M & Clark M

M. D. or other

Address

One Cedar St

Date signed 8-16-45



PLEASE WRITE PLAINLY, WITH UNFADING INK.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4B

07983

CERTIFICATE OF DEATH

Reg. Distr. No. 116

1. PLACE OF DEATH: Dorchester
 County: Cambridge
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 days
 Hospital, institution, or street address where death occurred: Cambridge Md. Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Dorchester
 City or town: Madison (If outside city or town limits, write RURAL and give nearest town)
 Street No.: none (If rural, give LOCATION)

3. (a) FULL NAME
Thomas C. Fitzburgh

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

B. (b) Name of husband or wife Fannie W. Woelford

7. Birth date of deceased (mo., day, yr.) Dec. 3 - 1885 6. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
59	8	27	hrs. min.

9. Birthplace Madison
 (Town, county, and state)

10. Usual occupation Farmer, Waterman

11. Industry or business a Lumberman

FATHER	12. Name
	John R. Fitzburgh
	13. Birthplace
	Madison

MOTHER	14. Maiden name
	Clementine Andrews
	15. Birthplace
	Jakesville, Dor Co

	16. Informant
	Mrs. Thos C. Fitzburgh
	Address
	Madison, Md.

17. Burial	Date thereof
(Burial, cremation, or removal. Which?)	Sept -1-1945
Cemetery or crematory	(month) (day) (year)
Location	<u>Madison M. C. Cemetery</u>

18. Funeral director	Kenneth R. Thomas
Address	Cambridge, Md.

19. Date rec'd by registrar	19. To John Mayle
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3. (b) Social Security Number
220-16-9997

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1945, at 12:25 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 26 1945, to Aug. 30 1945,
 and that I last saw him alive on Aug. 29, 1945.

Immediate cause of death

Barbituric acid
 Due to Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

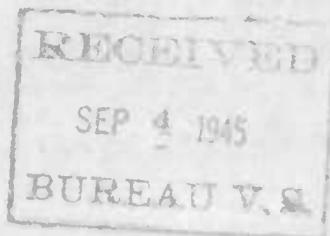
Means of injury

Injured at work?

23. SIGNATURE L. O. Meredith, M.D.
 M. D. or other

Address Cambridge, Md. Date signed Aug. 30, 1945

Registrar





PLEASE WRITE PLAINLY, WITH ENFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(B10)*

07985

CERTIFICATE OF DEATH

Reg. Dist. No. *16*

1. PLACE OF DEATH:

County *Dorchester*City or town *Cambridge*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *60 Years*

Hospital, institution, or street address where death occurred:

*200 High St.*How long in hospital or institution? *-*

3. (a) FULL NAME

*Edward W. Gibbons*3. (b) Social Security Number *-*

4. Sex <i>Male</i>	5. Color or race <i>White</i>	6.(a) Single, married, widowed, or divorced <i>Married</i>
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8. (b) Name of husband or wife *Elizabeth Marshall*
LeCompte Gibbons 8. (c) If alive, give age *81* years

7. Birth date of deceased (mo., day, yr.) *Dec. 30, 1860*

8. AGE: Years *84* Months *7* Days *10* 11 less than one day *hrs. min.*

9. Birthplace *Baltimore County*
 (Town, county, and state)

10. Usual occupation *Retired Farmer*

11. Industry or business

12. Name *Isiah Gibbons*
 MOTHER FATHER
 13. Birthplace *Maryland*

14. Maiden name *Elizabeth Young*
 MOTHER
 15. Birthplace *Maryland*

16. Informant *Mrs. E. W. Gibbons*
 Address *200 High St., Cambridge, Md.*

17. Burial Date thereof *Aug. 13, 1945*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory *Christ Church Cemetery*

Location *Cambridge, Maryland.*
 18. Funeral director *LeCompte's Funeral Service*
 Address *Cambridge, Maryland.*

19. *Aug 13-* 19. To *John Macdonald*
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Dorchester*City or town *Cambridge* (If outside city or town limits, write RURAL and give nearest town)Street No. *200 High St.*

(If rural, give LOCATION)

2.(a) If veteran, name war *-*

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 10th 1945*, at *3:30 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Aug 23rd* 1940, to *Aug 10* 1945; and that I last saw him alive on *Aug 6* 1945.

Immediate cause of death

Cerebral Hemorrhage

DURATION

*15 min.*Due to *Arteriole dilation**Cardiovascular Renewal**Diarrhea**5 days*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

No op.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

3. SIGNATURE

Eldridge H. Gibbons
 M. D. or other
 Address *Cambridge, Md.* Date signed *Aug 11 1945*

RECEIVED

AUG 16 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93A

07986

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:
Dorchester
County

City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? -

Hospital, institution, or street address where death occurred:
13 Cherry St.

How long in hospital or institution? -

3. (a) FULL NAME
Herman Everett Gootee

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Lottie Lane Gootee

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1883
6.(c) If alive, give age 52 years

8. AGE: Years 61 Months 11 Days 4 If less than one day hrs. min.

9. Birthplace Drawbridge, Dor. Co., Maryland.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

MOTHER FATHER 12. Name John W. Gootee
13. Birthplace Maryland

MOTHER 14. Maiden name Martha P. Sellers
15. Birthplace Maryland

16. Informant Mrs. Lottie Gootee
Address 13 Cherry St., Cambridge, Md.

17. Burial Date thereof Aug. 30, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Dorchester Memorial Park

Location Cambridge, Maryland.

18. Funeral director LeCompte's Funeral Service
Address Cambridge, Maryland.

19. 8/29/45 M.D. or other
(Date rec'd by registrar) Address John H. Gootee, Jr., Esq.
T. Registrar Date signed 8/29/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. 13 Cherry St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number
220-10-6755

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1945 at 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended decedent from August 30, 1945 to his death on August 28, 1945, and that I last saw him alive on August 28, 1945.

Immediate cause of death Cerebral hemorrhage

Due to Hypocardial fibrillation and auricular fibrillation

Due to Arteriosclerosis with hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

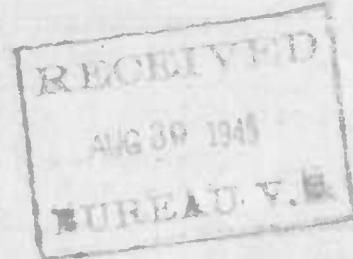
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE John H. Gootee, Jr., Esq.
M. D. or other

Date signed 8/29/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 140-1

CERTIFICATE OF DEATH

07987

Reg. Dist. No. 1K

1. PLACE OF DEATH:

County

City or town

Worchester
Cambridge, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

outside home

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Hilda A. Gordon

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

Divorced

8. (c) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age

years

October 10, 1920

8. AGE:

Years

Months

Days

If less than one day

24

10

6

hrs.

min.

9. Birthplace.....

Cambridge, Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

John W. Gordon

FATHER

12. Name.....

Barren Is. Dor. Co.

13. Birthplace.....

Dairy M. Prince

MOTHER

14. Maiden name.....

Cambridge, Md.

15. Birthplace.....

John W. Gordon

Cambridge, Md.

16. Informant.....

Address.....

Burial

Date of ref. (month) (day) (year)

(Burial, cremation, or removal, if any)

Cemetery or crematory.....

Cambridge

Location.....

Cambridge, Md.

18. Funeral director.....

Hermelinda K. Clowers

Address.....

Cambridge, Md.

19. (Date rec'd by registrar)

1945

J. J. G.

Regular

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Worchester

City or town.....

Cambridge, Md.

Street No.....

Roslyn Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

214-07-8692

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 16, 1945, at 10:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 15, 1945, to Aug. 16, 1945,

and that I last saw h. ER alive on August 16, 1945

Immediate cause of death.....

Myocardial Failure

DURATION

1 day

Due to TOXEMIA OF PERITONITIS

Due to Clostridium Welchii INFECTION

OF SEPTIC ABORTION

(Include pregnancy within 8 months of death)

Major findings or operations.....

PERITONITIS - CLOST. WELCHII

Date of op. 8/10/45

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

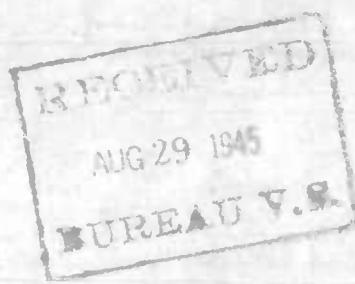
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

M. D. or other

Address Cambridge, Md. Date signed 8/18/45



PLEASE WRITE PLAINLY, WITH UNEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 140

07988

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County..... Dorchester

City or town..... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Philip Recitation Park

How long in hospital or institution?

3. (a) FULL NAME

Morris Edward Grant

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male Col. married

6.(b) Name of husband or wife..... Alverta Mccall

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age 25 years

July 15 - 1920

8. AGE: Years Months Days If less than one day

25 - 19 hrs. min.

9. Birthplace..... Crisfield - Md.

(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

12. Name..... Charles Lloyd - Md

13. Birthplace..... Md

14. Maiden name..... Essma Grant

15. Birthplace..... Md

16. Informant..... Alverta Grant

Address 819 Main St Crisfield - Md

17. Burial Date thereof AUG - 7 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Lawsonia Cemetery

Location..... Crisfield Md

18. Funeral director..... T. H. Harvey Bradshaw

Address..... Crisfield, Md

19. 8-7-1945 John May Jr. M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Somerset

City or town..... Crisfield

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 817 West Main St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 5 1945 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death.....

Coronary Disease

DURATION

1 day

Due to.....

Due to.....

Other conditions Possible Exophthalmic Goiter

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

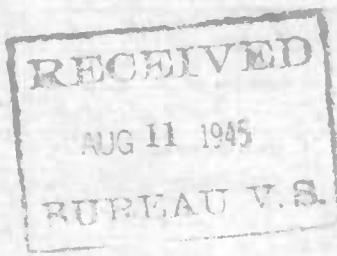
Injured at work?

23. SIGNATURE

M. D. or other

Address..... Cambridge - Md.

Date signed Aug 1945



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

07989

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH:
County Dorchester

City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 3 mos., 16 days

Hospital, Institution, or street address where death occurred: Eastern Shore State Hospital

How long in hospital or institution? 1 yr., 3 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Poconoke City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 Willow Street
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Claude M Henderson

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ida Henderson

7. Birth date of deceased (mo., day, yr.) April 19, 1892
6. (c) If alive, give age 51 years

8. AGE: Years 53 Months 3 Days 17 If less than one day hrs. min.

9. Birthplace Somerit County, Maryland
(Town, county, and state)

10. Usual occupation Gasoline Filling Station Attendant

11. Industry or business Retail Sales.

MOTHER FATHER 12. Name Henry Henderson

13. Birthplace Maryland

14. Maiden name Amanda Merrill

15. Birthplace Maryland

16. Informant Hospital Records

Address E.S.S.H., Cambridge, Md.

17. Burial Cemetery or crematory Salem M. & C. Cemetery Date thereof August 8, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Location Poconoke City Md.

18. Funeral director Marguerite K. Watson

Address Poconoke City Md.

19. 8-8-1945 John Mace J. H.
(Date rec'd by registrar) Registrars Address

3. (b) Social Security Number

213-05-1970

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1945, at 115 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19. to 19.

Immediate cause of death Suffocation (drowning) on 8/6/45
DURATION

Due to Probable asphyxia

Due to Post-traumatic mental

deterioration (Include pregnancy within 3 months of death) since 5/5/43

Major findings of operations Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Accident Date of 8/6/45

Where did injury occur? Cambridge Dorchester Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Eastern Shore State Hospital

Means of Injury Asphytic attack by tub. Injured at work? No

23. SIGNATURE Dr. H. Shriver, D.C. Med. Exam.

M. D. or other

Date signed Aug 6, 1945

RECEIVED

AUG 11 1945

BUREAU V.S.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *SH*

67990

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County..... Dorchester

City or town..... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, institution, or street address where death occurred:

Cambridge Maryland Hospital

How long in hospital or institution?..... 3 weeks.

3. (a) FULL NAME

Thomas Halliday Hicks

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

Rincke

7. Birth date of

deceased (mo., day, yr.)

Sept. 8, 1869.

(c) If alive, give age..... years

8. AGE:

Years	Months	Days	If less than one day
75	10	28	hrs. min.

9. Birthplace..... Neck Dist. Dor. Co. Maryland.

(Town, county, and state)

10. Usual occupation..... Retired Admiral

11. Industry or business

U.S.N.

12. Name.....

George Luther Hicks

13. Birthplace

MD.

14. Maiden name.....

Mary Rebecca Hicks

15. Birthplace

MD.

16. Informant..... Mrs. Chaplain Hicks

Address High St. Cambridge, MD.

17. Burial.....

(Burial, cremation, or removal. Which?) Date thereof Aug. 8, 1945

(month) (day) (year)

Cemetery or crematory.....

Cambridge Cemetery

Location.....

Cambridge, Maryland.

18. Funeral director..... LeCompte's Funeral Service

Address.....

Cambridge Maryland.

19. (Date rec'd by registrar)

8-8-45 John Deed J. M. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Dorchester

City or town..... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Oakley St.

(If rural, give LOCATION)

2.(a) If veteran, name war..... Retired Naval Officer & C. M. Navy

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 8, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. in alive on Aug. 6, 1945

Immediate cause of death..... Coronary Occlusion

DURATION

Due to.....

Due to.....

Other conditions..... Capillary of prostate

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

— w

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

w

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

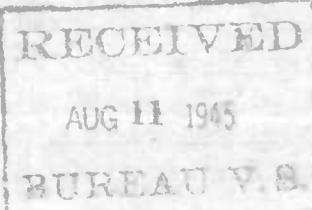
23. SIGNATURE..... Guy Stocke M.D.

M. D. or other

Address..... Cambridge Md. Date signed 8-7-45

Robert K. Higley

DEPARTMENT OF STATE WASHINGTON



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27

07991

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County... Dorchester

City or town... Rural--Andrews

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... Life

Hospital, Institution, or street address where death occurred:

Home--Andrews

How long in hospital or institution?

3. (a) FULL NAME

Octavia Sophrana Burton Hurley

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Married
------------------	---------------------------	---

6. (b) Name of husband or wife... Walter Hurley

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1870

6. (c) If alive, give age 71 years

8. AGE: Years 74	Months 10	Days 28	It less than one day hrs. min.
---------------------	--------------	------------	--

9. Birthplace Andrews, Dor. Co., Maryland

(Town, county, and state)

10. Usual occupation Practical Nurse

11. Industry or business Nursing

12. Name Not Known

13. Birthplace " "

14. Maiden name Not Known

15. Birthplace " "

16. Informant Mrs. Emerson Slacum

Address Andrews, Maryland.

17. Burial Date thereof Aug. 21, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Slacum Family Cemetery

Cemetery or crematory Location Lakesville, Maryland.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. 8-21-1945 John MacJ. Dow
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Dorchester

City or town... Rural--Andrews

(If outside city or town limits, write RURAL and give nearest town)

Street No... Andrews

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH August 18, 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15, 1945, to August 15, 1945;
and that I last saw her alive on August 15, 1945.

Immediate cause of death

acute peritonitis
(cardiac)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

O. H. Taeber

M. D. or other

Address Cambridge, Maryland Date signed August 21, 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 300

CERTIFICATE OF DEATH

07992

Reg. Dist. No. 116

1. PLACE OF DEATH:

County

Dorchester

Combside

Rural ✓

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Jackson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

colored

widow

6. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)

July 15 1885

6. (c) If alive, give age

years

7. Birth date of
deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

60

0

21

hrs.

min.

9. Birthplace

Annapolis

Md

(Town, county, and state)

10. Usual occupation

5 hr house work

11. Industry or business

12. Name

Joseph Hopkins

13. Birthplace

Maryland

14. Maiden name

Mary (P)

15. Birthplace

Maryland

16. Informant

John Mortimer

Address

Cambridge Road & Md

Burial

Date thereof 8-8-50

(Burial, cremation, or removal. Which?)

(month)

(day)

(year)

Cemetery or crematory

Cemetery

Location

Annapolis

18. Funeral director

Lewin J. Bayne

Address

Cambridge Rd.

8-1-50

to John May Jr

and

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Dorchester

City or town

Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Road ✓

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1950, at 6:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 24 1950, to August 6 1950,

and that I last saw her alive on August 1 1950.

Immediate cause of death

Chronic Bright's Disease

Acute Myocarditis

Aortic Thrombosis

Due to

Other conditions

Gen Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

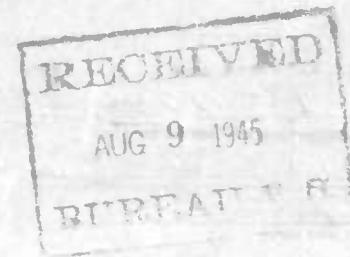
Means of injury

Injured at work?

23. SIGNATURE Carroll M. St. Clair M.D.

M. D. or other

Address 600 Harbor St Date signed 8-6-50



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07993

Reg. Dist. No.

116

1. PLACE OF DEATH:

County.....

Dorchester

City or town.....

Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

2 1/2

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Sarah Jane Jackson

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Negro Widowed

Samuel R. Jackson

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1874

6. (c) If alive, give age..... years

8. AGE: Years 71 Months 0 Days 11 If less than one day hrs. min.

9. Birthplace Cambridge, Md. (Town, county, and state)

10. Usual occupation Laundress

11. Industry or business

12. Name Moses Camper

13. Birthplace Aireys Dor. Co. Md.

14. Maiden name Frances Jenifer

15. Birthplace Cambridge, Dor. Co. Md

16. Informant Mrs Nannie Cooley

Address Easton, Talbot Co. Md

17. Burial Date thereof Aug. 16, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Waugh Cemetery

Location Cambridge Dor. Co. Md

18. Funeral director W. M. & Son

Address Cambridge, Md

19. 8-16-45 John Mack Jr. Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 257

High Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1945, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10, 1945, to Aug. 13, 1945,

and that I last saw her alive on August 13, 1945.

Immediate cause of death

Myocardial Failure

DURATION

6 days

Due to Toxemia -

Due to Osteomyelitis RT. LOWER EXTREMITY.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

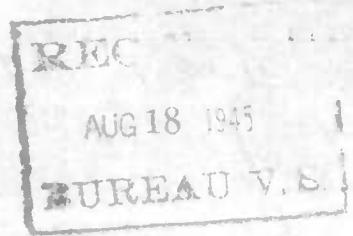
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other
Address Cambridge, Md. Date signed 8/14/45





PLEASE WRITE PLAINLY,
WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

CERTIFICATE OF DEATH

07994

Reg. Dist. No.116

1. PLACE OF DEATH:

County Dorchester

City or town Cambridge, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

H. Philip Draft

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife Lillie Marshall

7. Birth date of deceased (mo., day, yr.)

October 31, 1896

6. (c) If alive, give age 47 years

8. AGE:

Years

Months

Days

If less than one day

48

9

7

hrs. min.

9. Birthplace.....

Chaptank, Caroline Co.

(Town, county, and state)

10. Usual occupation.....

Slip Factory Operator

11. Industry or business

FATHER

12. Name.....

J. Harry Draft

13. Birthplace

Caroline, Md.

MOTHER

14. Maiden name.....

Elizabeth Philip

15. Birthplace

Kent Co., Md.

16. Informant.....

Mrs. H. Philip Draft

Address

Cambridge, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 8-11-45

(month) (day) (year)

Cemetery or crematory

Dorchester Memorial Park

Location

Cambridge, Md.

18. Funeral director

Kenneth D. Thomas

Address

Cambridge, Md.

19. 8-11-19

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Dorchester

City or town Cambridge (If outside city or town limits, write RURAL and give nearest town)

Street No. 504 Washington St. (If rural, give LOCATION)

Town none

2.(a) If veteran, name war

3. (b) Social Security Number

14-07-9990

MEDICAL CERTIFICATION

2D. DATE OF DEATH August 8, 1945, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1, 1945, to Aug. 8, 1945;

and that I last saw him alive on Aug. 8, 1945.

Immediate cause of death.....

acute Cardiac

or Colic

Cardio - Pericarditis

Due to.....

overload

Due to.....

overload

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other.....

Address..... Date signed.....

RECEIVED

AUG 16 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 118

CERTIFICATE OF DEATH

07995

Reg. Dlat. No. 111

1. PLACE OF DEATH:

County

Dorchester

City or town

East New Market Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

43 years

Hospital, Institution, or street address where death occurred:

none

How long in hospital or institution?

3. (a) FULL NAME

Mary Maddaline Elbert Mason

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife

John Mason

7. Birth date of deceased (mo., day, yr.)

Jan. 24, 1902

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

43

6

24

hrs.

min.

B. Birthplace

East New Market Md

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Aaron Dashfield

Md.

MOTHER

13. Birthplace

Nellie Nichols

Caroline Co.

14. Maiden name

Nellie Jenkins

18. Informant

Nellie Jenkins

Address

East New Market Md

Burial

Cemetery

Date thereof: 8/18/45

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

East New Market Md

18. Funeral director

T. B. Hellingsley

Address

Harsleby

19. Date rec'd by registrar

8/18/45

(Date rec'd by registrar)

19. Elizabeth C. Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town East New Market Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug 6 1945 at 1³⁰ AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 6 1945 to — 1945

and that I last saw her alive on Aug 6 1945

Immediate cause of death Indigitation septic 6 hours

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address: East New Market 8/18/45 Date signed

LETTER TO THE FEDERAL STATE COUNCIL
FOR THE ESTABLISHED
COUNCIL OF THE STATE



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

07996

Reg. Dist. No. 116

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Eliza Mc Knight

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female Colored Single

6. (b) Name of husband or wife

None Aug 20/18

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

27

Years
Months
DaysIf less than one day
hrs. min.

8. AGE:

27

9. Birthplace

Richmond, Va.

(Town, county, and state)

10. Usual occupation

House Works

11. Industry or business

Washington Mc Knight

12. Name

Richmond, Va.

13. Birthplace

Elizabeth Rose

14. Maiden name

Richmond, Va.

15. Birthplace

Albert Mc Knight

16. Informant

Burial

Address

Cemetery

Location

Silent City, Cambridge Md.

17. Funeral director

Sequoia Corp. members

Address

101 Washington St, Camb.

8-28-1945

(Date rec'd by registrar)

John May Jr.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Cambridge

Street No.

Center St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 21 1945 at 5 P.M.

Sept 9 1945 to Aug 24 1945
and that I last saw her alive on Aug 24 1945

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Tuberculosis, Right knee

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

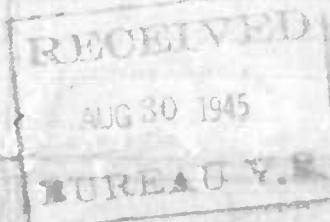
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Debra E. Brucker M. D. or other

Address Cambridge Md. Date signed 8-25-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 40

07997

116

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County

City or town

Dorchester
Cambridge Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Emma Plotter

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female Col widow

6. (b) Name of husband or wife

George Plotter
Oct 14

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

.... hrs. mto.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

FATHER

12. Name

Virgil Nichols

MOTHER

13. Birthplace

Maryland

14. Maiden name

Julia Moore

15. Birthplace

Maryland

16. Informant

Fred Chester

Address

Pine St Cambridge

17. Burial

Date thereof Sept 7 1945

(Burial, cremation, or removal. Which?)

Cemetery

Location

Christ Rock

18. Funeral director

Sewell & Bryneum

Address

Cambridge Md

19. Date rec'd by registrar

9/1 1945 John Mac G. T.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Dor.

City or town

Cambridge (If outside city or town limits, write RURAL and give nearest town)

Street No.

Gulf St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 7 1945 at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 10 1945 to Aug 7 1945

and that I last saw h... E.R. alive on Aug 7 1945

Immediate cause of death

Myocardial failure

Due to Coarctation of aorta

Stomach

Other conditions Rheumatoid Arthritis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. J. James M. D. or other

Address: Cambridge, Md. Date signed 9/1/45

RECEIVED

SEP 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Mo.*

07998

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:
County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years
Hospital, Institution, or street address where death occurred:
104 Robbins St.

How long in hospital or institution?

3. (a) FULL NAME
Granville Pritchett

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Married
-------------	------------------------	---

B. (b) Name of husband or wife Libby May Mills

7. Birth date of deceased (mo. day, yr.) July 7, 1891

8. AGE: Years 54 Months 1 Days 22 If less than one day
..... hrs. min.

9. Birthplace Bishops Head, Dor. Co., Md.
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Grocery Store

MOTHER FATHER 12. Name John W. Pritchett

13. Birthplace Maryland

14. Maiden name Susan Lewis

15. Birthplace Maryland

16. Informant Weldon Pritchett

Address 104 Robbins St., Cambridge, Md.

17. Burial Date thereof Sept. 2, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenlawn Cemetery

Location Cambridge, Maryland.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. (Date rec'd by registrar) 9-1-45 John Tracy Jr. Registrar
Address

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 104 Robbins St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1945 at 5:25A

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 26 1945 to Aug. 29 1945 and that I last saw b. 17 alive on AUGUST 29 1945

Immediate cause of death Myocardial Failure DURATION 3 days

Due to Bronchial Asthma ?

Due to Lymphatic Leukemia

Other conditions Rheumatoid Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No. Date of

Accident, suicide, or homicide.

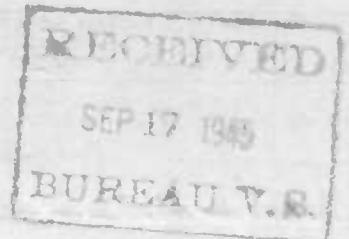
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *W. J. P. Pritchett* M. D. or other

Address Cambridge, Md. Date signed 9-1-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B-2

CERTIFICATE OF DEATH

07999

116

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

1. PLACE OF DEATH:
 County..... Dorchester
 City or town..... Cambridge
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 days
 Hospital, institution, or street address where death occurred:
 Cambridge Maryland Hospital
 How long in hospital or institution?..... 3 days

3. (a) FULL NAME

Edward Richards

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	colored	married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Unknown

6. (c) If alive, give age..... years

8. AGE:	Years	Months	Days	If less than one day
	75			hrs. min.

9. Birthplace..... Seaford Delaware

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....	Aaron Richards
---------------	----------------

13. Birthplace	Delaware
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14. Maiden name.....	Belle
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15. Birthplace	Delaware
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16. Informant.....

Address.....

17. Burial, cremation, or removal (where?)	Date thereof.....	8-8-45	
Cemetery or crematory.....	(month)	(day)	(year)

Location.....	Cambrelidge Md.
---------------	-----------------

18. Funeral director.....	Lewis H. Baugher
---------------------------	------------------

Address.....	Cambridge Md.
--------------	---------------

19. (Date rec'd by registrar)	19-65
-------------------------------	-------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....	County.....
City or town.....	<small>(If outside city or town limits, write RURAL and give nearest town)</small>
Street No.....	<small>(If rural, give LOCATION)</small>

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 5 1945 at 6¹⁰ AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1 1945 to Aug 5 1945 and that I last saw him alive on August 4 1945.

Immediate cause of death..... Tremor

Due to..... Cardiac fibrillation & cardiac decompensation

Due to..... Acute intestinal obstruction

Other conditions..... Encrusted faeces

(left) or rectum

(Include pregnancy within 3 months of death)

Major findings or operations..... Incarcerated & obstructed loop

Small intestine w/ left transverse Date of op. 8-2-45

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

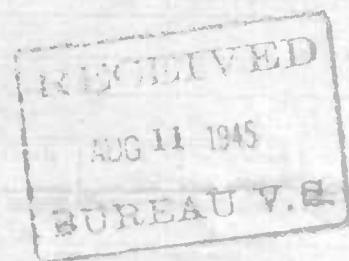
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Alpha R. Drury, M.D. M. D. or other

Address..... Cambridge Md. Date signed..... 8-8-45

VS A15



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(Handwritten)*

08900

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:

County *Dorchester*City or town *East New Market - Rural*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Life*Hospital, Institution, or street address where death occurred: *Near Shiloh*How long in hospital or institution? *-*

3. (a) FULL NAME

Charles Thomas

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male**Colored**Married*

6. (b) Name of husband or wife

*Annie Thomas*6. (c) If alive, give age *79* years

7. Birth date of deceased (mo., day, yr.)

June 15, 1868

8. AGE:

Years

Months

Days

If less than one day

*77**1**26*hrs. *.* min.

9. Birthplace

Dorchester County, Maryland

(Town, county, and state)

10. Usual occupation

Farm Worker

11. Industry or business

Farm

MOTHER

FATHER

12. Name

Henry Thomas

13. Birthplace

Dorchester County, Maryland

MOTHER

FATHER

14. Maiden name

Milky Earl

15. Birthplace

Dorchester County, Maryland

16. Informant

Mrs. Annie Thomas

Address

East New Market, Maryland, P.O.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *August 14, 1945*

(month) (day) (year)

Cemetery or crematory *Thompsonstown Cemetery*Location *Near East New Market, Maryland*

18. Funeral director

Address

*J. T. Trumpton and Son**Teddytown, Maryland*19. *Aug. 13, 1945*
(Date rec'd by registrar)*Chas. W. Hodges
Registrar*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Dorchester*City or town *East New Market - Rural*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *7 near Shiloh*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 11 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Bornce May 1, 1944 1944and that I last saw him alive on *Aug. 10 1945* 1945

Immediate cause of death

*Chronic Appendicitis*Due to *Appendicitis*

DURATION

Due to

Some neglected

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

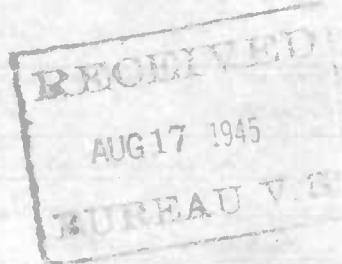
Injured at work?

23. SIGNATURE

L. G. Hodges

M. D. or other

Address *World of Work*Date signed *Aug. 14, 1945*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1950

08901

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County..... Dorchester
 City or town..... Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all of life

Hospital, institution, or street address where death occurred: Cambridge Maryland Hospital

How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Dorchester
 City or town..... Cambridge
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Washington St.
(If rural, give LOCATION)

3. (a) FULL NAME

Samuel F. Thompson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE:	Years	Months	Days	If less than one day
	70	#	#	hrs. min.

9. Birthplace..... Maryland

(Town, county, and state)

10. Usual occupation..... Labour

11. Industry or business.....

12. Name..... Samuel Thompson

13. Birthplace..... Taylor Island, Md.

14. Maiden name..... Hester Smith

15. Birthplace..... Camb. Md.

16. Informant..... Mary Leene

Address..... Cambridge, Md.

17. Burial..... Burial

(Burial, cremation, or removal. Which?) Date thereof..... 8-19-45

(month) (day) (year)

Date thereof..... 8-19-45

Cometory or crematory..... Taylor Island Cemetery

Location..... Taylor Island, Md.

18. Funeral director..... Lewis H. Baumhamer

Address..... Cambridge, Md.

19. 8-16-18 A.M.

(Date rec'd by registrar)

19. 8-16-18 A.M.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 18 1945, a.m. 7-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 10... and that I last saw him alive on 19...

Immediate cause of death..... Shock

Due to..... Struck by falling tree

Due to..... Struck by tree

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of Aug. 15/45

Where did injury occur? in: Cambridge, Md. (City or town) (County) (State)

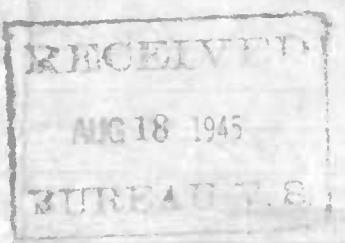
Injured at home, farm, industry, public place (where?) in woods

Means of Injury..... Falling tree Injured at work? Yes

Signature..... J. H. Shriver, D.P.M., F.A.C.P.

M. D. or other.....

Address..... Cambridge, Md. Date signed Aug. 15/45



M
1
PLEASE WRITE PLAINLY, WITH
FADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

08002

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester

City or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Mths.

Hospital, institution, or street address where death occurred:

10 Light St.

How long in hospital or institution?

3. (a) FULL NAME

Hannah Smith Todd

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife... Cleveland R. Todd

7. Birth date of deceased (mo., day, yr.)

Sept. 23, 1884.

6. (c) If alive, give age 61 years

8. AGE:

Years 60

Months 10

Days 15

If less than one day hrs. min.

9. Birthplace Selbyville, Delaware

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

12. Name Not Known

MOTHER FATHER

13. Birthplace II

14. Maiden name II

15. Birthplace II

16. Informant Cleveland R. Todd

Address 319 Locust St., Cambridge, Md.

Burial

Date thereof Aug. 10, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Donoway Family Cemetery

Location Selbyville, Delaware

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. 8-10-1945 John Doe J. M. D. Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Cambridge (If outside city or town limits, write RURAL and give nearest town)

Street No. 319 Locust St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 8 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

19.

Immediate cause of death

Disease of Coronary Arteries

DURATION

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

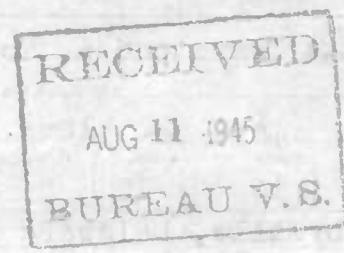
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cambridge, Md. Date signed Aug 9/45



Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
is shown on

08003

2411 N. Charles St., Baltimore 33d

G 97 SEP 10 1945

CERTIFICATE OF DEATH

Reg. Diat. No. 116-119

1. PLACE OF DEATH:

County Dorchester

City or town Rural-Bishops Head

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Week

Hospital, institution, or street address where death occurred:

Bishops Head

How long in hospital or institution? -

3. (a) FULL NAME

Susie Pritchett Todd

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife James E. Todd

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1866

6.(c) If alive, give age 81 years

8. AGE: Years Months Days If less than one day

78 -79- -1- 11 23 hrs. min.

9. Birthplace Bishops Head, Dor. Co., Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Domestic

12. Name Zebedee Pritchett

13. Birthplace Bishops Head, Ma.

Margaret Moore

14. Maiden name Mrs. Elsa Dayton

15. Birthplace Bishops Head, Ma.

Mrs. Elsa Dayton

16. Informant Cambridge, Maryland.

Address

17. Burial Date thereof Aug. 23, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Church Cemetery

Location Toddville, Maryland.

18. Funeral director Recombe's Funeral Service

Address Cambridge, Maryland.

19. Date rec'd by registrar Aug 22 1945 Wilson & Pritchett

Cocac Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Rural-Toddville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Toddville

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Chronic Myocarditis several years

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

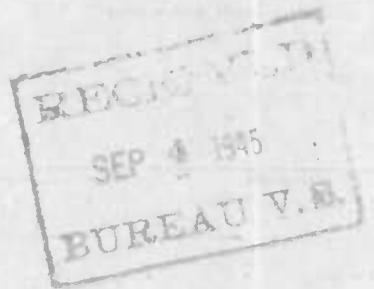
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joe H. Shriver, Del. Med. Exam.

M. D. or other

Address Teambridge-Ma Date signed Aug 22 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

08004

CERTIFICATE OF DEATH

Reg. Dlat. No. 111

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred: _____

How long in hospital or institution?.....

3. (a) FULL NAME

George Albert Young,
Male white Widower

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)

8. (c) If alive, give age _____ years

May 3 1899

8. AGE:

Years
46Months
5

Days

If less than one day
hrs. min.

9. Birthplace.....

(Town, county, and state) MD

10. Usual occupation.....

Singer

11. Industry or business

FATHER

12. Name..... John W Young

13. Birthplace..... MD

MOTHER FATHER

14. Maiden name..... Anna Redd

15. Birthplace..... MD

16. Informant..... John W Young

Address..... East New Market

17. (Burial, cremation, or removal, which?)

Date thereof..... Aug 29 1945

(month) (day) (year)

Cemetery or crematory..... Cemetery

Location..... East New Market

18. Funeral director..... J. B. Kilgough

Address..... East New Market

19. Date record by registrar..... Aug 28 1945

Elizabeth C Smith

(Date record by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Dorchester

City or town..... East New Market

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 26 1945 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 26 1945 to 1945

and that I last saw him alive on Aug 26 1945

Immediate cause of death..... Appendicitis

DURATION

Due to.....

Due to.....

Other conditions.....

(Indicate pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE..... P. D. Brown M.D.

M. D. of other

Address..... East New Market Date signed..... Aug 28 1945

RECEIVED
SEP 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

08905

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester

City or town Rural-Cambridge

(If outside city or town limits, write RURAL and give nearest town)

9 Yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Ross Neck, RFD # 3

How long in hospital or institution?

3. (a) FULL NAME

Harry B. Young

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1878

6.(c) If alive, give age years

8. AGE:

Years 67 Months — Days — If less than one day hrs. — min.

B. Birthplace

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Dirt

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Mr. Everett Marshall

Address

RFD # 3, Cambridge, Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof 8 22-45

(month) (day) (year)

Cemetery or crematory

Kenneth Square Cemetery

Location

Kenneth Square, Pa.

18. Funeral director

LeCompte's Funeral Service

Address

Cambridge, Maryland.

19. (Date rec'd by registrar)

8-21-19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Dorchester

City or town Rural-Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ross Neck, RFD # 3

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 20 1945 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to... 19...

and that I last saw h. alive on

Immediate cause of death

Chronic Myocarditis ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. or other

Address

Dr. J. H. Shriver Dap Med Exam
Cambridge, Md. Date signed Aug 1945

